...Disgrace

...omoted by the Manitoba Indian Brotherhood, was financed ...y a federal Local Initiatives Program grant. It, too, is run entirely by In...dians, five nurses and a social worker.

Only 221 Canadian nurses are Indian. They recently formed an association, Registered Nurses of Indian Ancestry, and one of their intentions is to inspire more native girls to enter the profession. The best guess is that there are only one Inuit and nine Indian doctors in the country. Medical Services couldn't even make a guess, which is a telling indication of how it has divorced itself from any encouragement of native Canadians to study medicine.

Native organizations have complained for years about how few of their own people manage to enter the medical profession. The National Indian Brotherhood has suggested training native people as true paramedics, instructed practically yet without long years of university study, much like the "barefoot doctors" who dramatically improved the health of the Chinese. And the Inuit Tapirisat of Canada, the Eskimo brotherhood, recommends that medical pre-training centres be established in the North to prepare Inuit students in their own setting before they attend alien southern universities.

But no outside help will work unless native people can regain their self-esteem. Dr. Charles Simpson of Victoria, the former chairman of an Indian health committee for the British Columbia Medical Association, has written: "Health cannot come without self-respect. Self-respect in a group cannot occur without political awareness. The development of political awareness is a turbulent process and has its own priorities — health is not high on that list. Land is. Land claims are top priority in the (Indians') political awareness program. . . ."

The paradox of the back-to-the land camps and any other attempt to restore native self-esteem is that they can't succeed without the sympathetic support of the white population. If we want the physician and mental well-being of native Canadians to improve, governments and individuals must continue to offer practical and often expensive assistance.

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Health Care in a Central Canadian Arctic Community: Continuities and Change*

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The health-care delivery system in Canada has been variously described and criticized as manifesting many of the symptoms typically associated with industrialized, capitalist political economies: an emphasis on specialized, hospital-based medicine as opposed to community-based, ambulatory care; a focus on curative rather than preventive treatment; a concern with personal rather than public and environmental health; and a system structured to protect the expensive vested interests of the professionally dominant segment of health workers — physicians (Ontario Economic Council, 1976; Government of Quebec, 1970; Ontario Committee on the Healing Arts, 1970). More recently, both social scientists and administrators have indicated that alternative models for health-care delivery are needed to overcome both the economic inefficiency and the medical inadequacies that are intrinsic to the contemporary health-care delivery system (Lalonde, 1974). Concomitantly, the current literature on the provision, cross-culturally, of scientific medicine emphasizes the improved chances of acceptance and increased efficiency of health services when delivery of services is tailored to community needs (Foster, 1977).

With these general trends in mind, this chapter will report on research conducted in a Canadian Inuit community to describe a unique model of health-

*This paper originally appeared in the first edition. New material has been added, and minor editorial changes have been made. The anthropological fieldwork for this paper was carried out in a Canadian Inuit community from 1977 to 1978. Subsequent fieldwork in 1982 and two years of postdoctoral research into northern health policy provide supplemental data. The financial assistance of the National Health Research and Development Program, Health and Welfare Canada, the Institute for Northern Studies, the University of Saskatchewan and the Arctic Institute of North America made this research possible. I would also like to express my gratitude to the people of Pulaktuq and to the nursing staff employed there, whose co-operation made the research both fruitful and pleasant.

care delivery that evolved to meet specific geographical and cultural needs.

The initial portion of this chapter will briefly describe the health-care system of traditional Inuit society and detail the historical influences that have resulted in changes in that system. Following this description is a concise outline of the structure and culture of the cosmopolitan health-care system that has been introduced into the Canadian North. Finally, a series of case studies will illustrate the way in which Inuit understand and deal with health problems in the contemporary context. In the final conclusion and analysis section, this material will be related to the general question of tailoring health-care delivery systems to specific health-care needs.

The research was carried out in traditional anthropological fashion, relying primarily on participant observation, unstructured interviews and life histories. The majority of interviews and conversations were conducted with the aid of Inuit interpreters. Various personnel in both administrative and service roles in Medical Services were also interviewed, including almost all those involved in direct administrative positions relating to Inuit health care.

Traditional Health and Illness Beliefs and Practices

As is the case in most non-Western or traditional societies, illness among the Inuit was primarily a psycho-social rather than a physical or biological occurrence. Although a given illness may have had physical manifestations, the Inuit theory of disease explained symptoms by appealing to various social and psychological causes. Both physical and mental disorders were considered to be situational in origin and consequently both amenable to therapeutic techniques and ultimately resolvable.

The core of this belief was the theory that serious physical and mental disorders were ultimately caused by personal behaviour deviations from the accepted social etiquette. Informants listed these irregularities as "expressing hostility, aggressive behaviour, jealousy, brooding, wishing another harm, thinking too much and adulterous desires." Ethnographic reports expand this etiology to include a vast number of taboos that affected nearly every aspect of daily life (Rasmussen, 1929; Boas, 1888). Transgressions by an individual could result in cosmological disturbances, such as spirit intervention or soul loss. These effects would manifest themselves in the form of physical and/or mental debilitation in either the individual who had committed the transgression or in other members of his family. The majority of cases cited by informants seemed to indicate that the causal effect was reflective in the sense that, if the person committing the transgression did not become ill, then the victim would be someone close to him, such as a child. There was also mention, however, of more directed illness causing, usually involving malevolent shamans or very strong-minded older people who, sometimes on the verge of death, would direct the illness-causing spirits to harm someone else.

The shaman's curing role was to ascertain the original cause of the problem

and retrieve the soul of the afflicted person or drive the "infecting" spirits out of his body. The most often described ritual was the *Kilaruq*, a ceremony where a shaman would attempt to diagnose the cause of a person's illness.[1] The sick person and members of his or her family would sit in a circle around the shaman and his prone assistant inside the snow house. The shaman would pull on a cord tied around his assistant's head while stating possible causes for the sick person's illness. These diagnostic statements usually involved some breach of social taboo, which would range from the improper butchering of game, to mistreatment of dogs, to incest. The shaman's spirit helpers would know which of these taboos had been broken and would hold down his assistant's head when the shaman uttered the correct diagnosis. If the cause was publicly acknowledged by the sick person or a member of his family, then the sick person's soul would return to his body and he would get well.

Aside from those psycho-social curing techniques, the Canadian Inuit are somewhat unique among traditional societies insofar as they lack an extensive pharmacopoeia. Virtually all human groups apart from the Inuit make extensive use of the local flora and fauna in the preparation of remedies for dealing with illness, usually in conjunction with psycho-social therapeutic techniques. Although the Inuit did make use of some practical remedies, such as the use of a lemming skin for treating boils, their environment limited the development of other remedies. There are some exceptions to this general rule among people in less severe environments, such as Alaska and northern Quebec where a more extensive pharmacopoeia was in use (Lantis, 1959; Avatoq Cultural Institute, 1984).

We should note here, however, that this description of the Inuit theory of disease and curing practices is a necessarily truncated version of reality — somewhat analogous to reducing all of Western medicine to germ theory and chemotherapy. While this synopsis describes the core of the Inuit traditional medical belief system, there were many permutations and alternatives to the beliefs and practices described.

Postcontact Changes in Illness Beliefs and Practices

The traditional Inuit world view that supported the stature of the shaman was fragile in the sense that all activities — economic, social, political and religious — were interrelated and linked to the central tenets of the world view. Threats or challenges to any one realm of belief thus served to undermine the entire system. Consequently, when in the latter part of the nineteenth century early contact was established with traders and explorers, the success of the invaders' survival techniques brought with it doubt about the efficacy of the traditional belief system. The effect was a diminishing of support for the shaman's omniscience.

The sequence of historical events that further served to challenge the traditional health-care system in Pulaktuq (a pseudonym) is summarized below:

1. In 1927, the Hudson's Bay Company established a trading post. Bay managers had medicine chests available and stocked nonprescription drugs, which were demonstrably effective in relieving symptoms.
2. In 1929, a number of devout Anglican Inuit from the eastern Arctic, who were on board the Fort James, a federal ship that wintered in Pulaktuq, convinced many local Inuit that shamans were evil and that prayer was more efficacious than traditional practices when confronted with supernatural disturbances such as illness.
3. In 1948, a physician flew into Pulaktuq to conduct the first X-ray tests for tuberculosis, but, in the process, he brought an influenza virus that was responsible for possibly seventeen deaths in Pulaktuq and vicinity.
4. In the 1950s, a measles outbreak was responsible for a few more deaths.
5. In 1958, a serious famine affected the people in the hunting camps, causing further deaths and the permanent displacement of several families to Pulaktuq and other settlements in the area.
6. Throughout the 1950s and 1960s, the rate of tuberculosis was extremely high, and a significant number of individuals were evacuated to sanatoriums in the south for treatment.
7. In 1958 and 1959 respectively, Roman Catholic and Anglican missions were established in Pulaktuq, and the missionaries attempted to repress shamanism. The Catholic mission dispensed medications, cared for orphaned children and fed needy families.

The consequence of this developmental period was a restructuring of Inuit beliefs about illness. During the early sixties, a new theory of disease emerged that overlaid and interrelated with, but did not replace, the traditional beliefs. Inuit now believed that some diseases were directly caused by non-Inuit people and that a combination of drugs, prayer and shamans' practices were effective ways of dealing with these illnesses. Social transgressions were still, however, important "ultimate causes" in Inuit understanding of the illness process.

For instance, as recently as 1970, a young man suffering considerably from influenza, after unsuccessful treatment at the recently constructed Nursing Station, participated in a *Kilaruq* conducted by a shaman in Pulaktuq. The cause of the disease was diagnosed as the mistreatment of his stepmother by his father. Once this behaviour was publicly acknowledged by the father, the patient made a rapid recovery.

In recent years, a third component to Inuit disease theory has developed. Garbage, sewage and soot from the furnaces are viewed as the cause of the greater frequency of illnesses in town than in camp. Informants stated that the reason the camp was healthier was its cleanliness as opposed to the dirt, overcrowding, hot houses and travelling non-Inuit associated with settlement life.

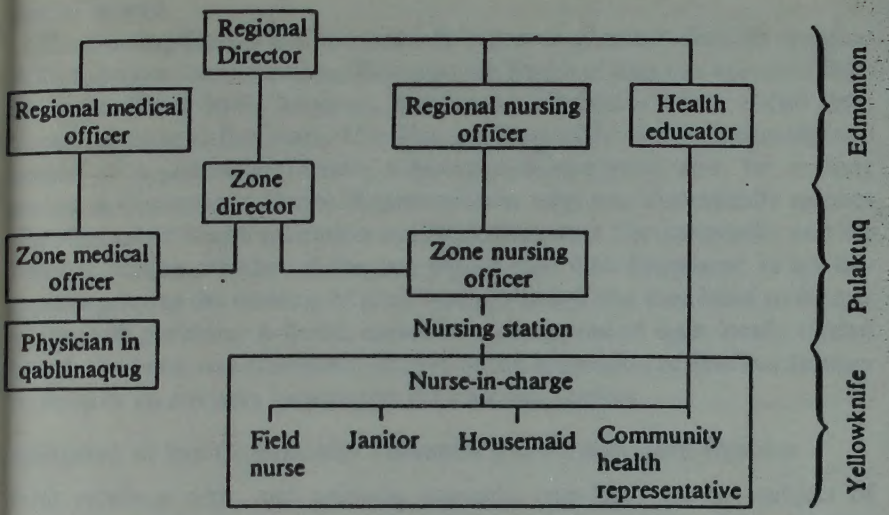
In summary, current Inuit disease theory attributes the ultimate cause of illness to social transgressions, with bad spirits, visiting non-Inuit and poor public-health standards in town as mediating agents. Effective methods of coping with illness range from shamans' rituals through Christian prayer, to dependence on the cosmopolitan medicines and the techniques of the Nursing Station. This belief system is an integrated whole, and each aspect influences the other components. Moreover, each person internalizes this system to varying degrees, emphasizing some aspects over others. In particular, the more traditional aspects are less significant to the younger members of the population. With this background in mind, attention will now be focussed on the introduction of cosmopolitan medicine to the community of Pulaktuq, examining initially the structure and prevailing attitudes of the responsible health organization.

Bureaucratic Organization and Attitudes of Medical Staff to Health Care in Inuit Communities

Responsibility for the provision of health services to Canada's native and northern populations is federal, with National Health and Welfare's Medical Services Branch, Northwest Territories Region, providing those services in Pulaktuq. The territorial government is responsible, however, for the health-insurance plan that finances a significant portion of the services. This federal-territorial division of responsibility for northern public services is represented at the community level by the Nursing Station, the sole physical evidence of the federal government.[2]

Structurally, Northern Medical Services is extremely complex, and it is beyond the scope of this study to discuss its organizational form in detail. Several important structural features are worth noting, however. Each northern "region" is subdivided into "zones." Most Nursing Stations are staffed exclusively by nurses (often with "practitioner" or "midwifery" expertise) who hold primary responsibility for community-level treatment and other health services. A doctor (usually a general or family practitioner) is generally located in the largest community in each zone and provides consultation and advice to the nurses in their respective zones. The nurses in each station are responsible to a zone nursing officer who is, in turn, responsible to the zone director, an administrative and nonmedical position. The following simplified diagram illustrates the structural features of the system as it relates to Pulaktuq.

Northern Medical Service Regional Organization Figure 1:



The chief attitudes and orientations that affect the delivery of health care in Pulaktuq can be summarized as follows:

1. A conflict in attitudes between administrators and field staff towards the role that the Nursing Station should play in community health. Administrators tend to believe that field staff should operate according to standard, rather restricted guidelines concerning involvement in community affairs, whereas some field staff feel that the Nursing Station is an integral part of the community and should respond realistically to any demands placed upon it.
2. Variation in recognizing the clients' culture as an important variable. These attitudes range from an extreme where an administrator feels that culture is as irrelevant to the provision of health services as it would be to the supply of car parts, to the other extreme where the field nurse attempts to learn the local language, pays attention to kinship patterns and acknowledges and respects suggestions arising from community needs. Most attitudes fall somewhere in between. There is also a general administrative orientation to devalue Inuit customs exemplified in the low priority given to orienting field staff to Inuit culture.
3. A recognition and concern among northern medical specialists and practitioners that many of the current medical problems are of a social and cultural origin (cf. Schaefer and Metayer, 1976).
4. Conflicting attitudes towards the value of public-health education. Despite vocal commitment at the administrative level, structurally and practically, health education receives little support at the field level where its value is recognized.
5. Ambiguity over the lines of authority, particularly with respect to the authority of the physician stationed in Qablunaqtuq versus that of nurses in the Nursing Station.

Notable, then, are the differences in attitudes and values between the administrative staff and some of the medical field personnel. It is important to note that administrators argue that their approach to health care in the communities is constrained by the financial resources available to them and problems with recruiting new staff. Our data suggest, however, that regional administrators are disinclined to challenge the policy decisions that structure the economic context in which they work. For example, in a meeting with a Hamlet Council to discuss problems with the local Nursing Station, a regional director made the following statement:

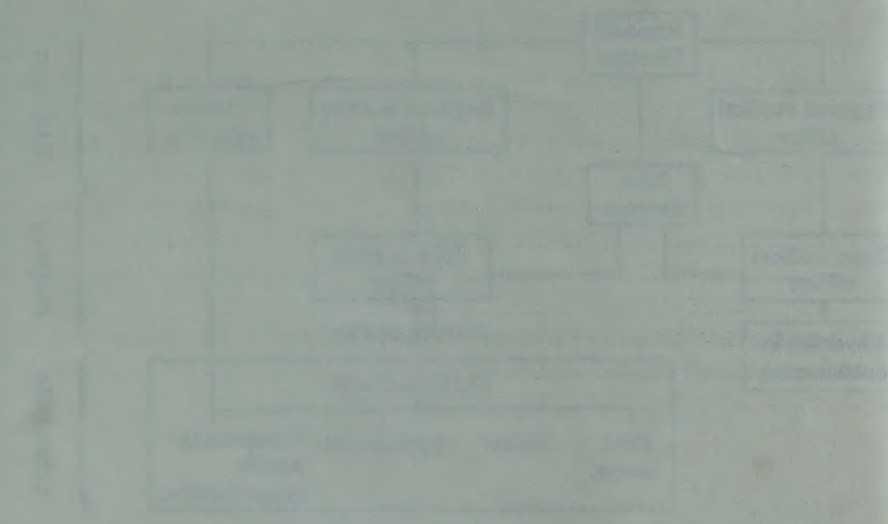
> The nurse, although she is alone here, does not make all the decisions with respect to health care. Even though I am the Zone Director, there are some decisions about health care that I cannot make. We operate on the basis of a policy that is set in Ottawa by Medical Services Branch as to how babies are going to be delivered. This policy or the practice of delivering babies is based on a policy set in Ottawa. In this respect it has nothing to do with what the nurse wants. She has to take directions from her supervisor who takes directions from the policy that has been established. And the last point I want to make is that you shouldn't feel badly about making this suggestion, because the previous Council made a similar suggestion and I recall meeting with the previous Council and explaining our policies. I wish I could make the decision myself but I have to carry out the mandate or the work of Medical Services Branch.

Rather than facilitating local-level input into policy, regional administrators tend to view their roles as defenders of policy originating in Ottawa.

Contemporary Health Care in Pulaktuq

Background

The Nursing Station in Pulaktuq was built in 1970. For five years prior to its opening, medical care was the responsibility of the local lay dispenser, an



Inuk trained to carry out basic primary care under the indirect supervision (short-wave radio) of the nurses stationed in Qablunaqtuq, two hundred and fifty miles away. Space was made available in the Roman Catholic Mission for the lay dispenser and visiting medical personnel to conduct clinics. Persons with serious illnesses were flown to Qablunaqtuq or to the hospital in Edmonton. There is some evidence that shamans were still active during this period as well.

The Nursing Station has had a steady turnover of nurses since its opening. With some notable exceptions, their average length of stay was approximately one year. There have, however, been several instances where nurses have stayed for three to five years. The other staff are all from the community and consist of a janitor-interpreter, a housemaid-interpreter and, for a short period, a Community Health Representative, who was theoretically responsible for public-health education and liaison between the community and the Nursing Station. Neither of the two young men who functioned as lay dispensers prior to the opening of the Nursing Station was ever hired to fill any of the staff positions. A health committee, composed of eight locally elected board members, was established in 1975 at the suggestion of Medical Services to serve in an advisory capacity to the Nursing Station.

Attitudes of the Community Towards the Health-Care System

Inuit relations with, and attitudes towards, non-Inuit are the subject of several studies (see especially Brody, 1975, and Paine, 1977). The main characteristic of these relations is the attitude of *ilira*, which translates best as respect tinged with fear (Briggs, 1970). *Ilira* is the essential element in a relationship in which one of the parties has historically wielded extraordinary power in the daily lives of the other party and whose behaviour is, to a large extent, viewed as volatile and unpredictable. Although there are exceptions, cultural and linguistic differences usually dictate a distinct social distance between the non-Inuit transients and their Inuit clients. Lack of familiarity thus increases misconceptions and stereotypic responses between the two groups.

The quality of the relationship between nurses and community, while generally as described above, does, however, exhibit several variations. Of all the non-Inuit transients that visit northern settlements, nurses tend to interact with a larger proportion of the population and with greater frequency. They are genuinely "liked" to a greater degree, and consequently, *ilira* is minimized. However, there is also a profound recognition of the power and knowledge exhibited by nurses, and the personal social behaviour of the nurses determines the degree to which this recognition is tinged with fear.

Inuit are very sensitive to the sincerity of non-Inuit people's actions and react profoundly to behaviour interpreted as patronizing or ridiculing. This sensitivity in combination with the high degree of anxiety that almost universally accompanies sickness has resulted in instances where nurses are feared

outright and communities have lobbied hard to have them transferred elsewhere.

Several older people in the community made reference to the fact that nurses performed a similar function to the shamans. The efficacy of cosmopolitan medicine was attributed to what they saw as the personal power of individual nurses, in much the same way as the success of a shaman depended on his command over the spirit world. Similarly, most people did not view doctors as a separate category of health worker but merely as a more powerful nurse.

In the modern context, the power that historically was wielded by local non-Inuit administrators is tempered by the growth of various locally elected committees, councils or boards of directors. As their confidence in assuming responsibility over areas of community life grows, Inuit are less likely to acquiesce to non-Inuit decisions and demands if they are perceived as contradictory to local needs. This is not the case with respect to the Nursing Station, however, where the advisory committee has only token responsibility and the local people have virtually no influence in decision making. And, in general, a medical "request" is still very often understood as a "command." This is particularly true when people are flown out for procedures in southern hospitals. Very few people recognize that other options may be available or that they have a choice when asked for their consent. For older people particularly, who might be willing to accept certain risks in order to avoid dying in a southern hospital, this is an important issue.

The nurse's unquestioned authority in clinical situations is, however, challenged on other levels. Resistance to public-health initiatives, such as classes on personal hygiene, can be understood in this context. Older women will argue that "the nurses are always telling us to keep our houses clean and we don't like that. We do our best but we don't have the equipment (i.e., running water, washing machines, vacuum cleaners, etc.) that the Nursing Station has and the nurses are never satisfied." Furthermore, young entrepreneurial Inuit who hold responsible positions in the local administrative structure translate their resentment of the power the nurses wield into uncooperativeness in interagency relations.

Local Structural Issues Affecting Agency Co-operation in Health Programs

Until very recently, the colonial nature of administration in the Northwest Territories was apparent by virtue of the fact that the local political structure was a reflection of the segregation of responsibility into distinct bureaucratic departments in the Territorial government. Each agency providing a service to the community, be it Medical Services, Department of Social Development, Department of Education, Department of Economic Development, Department of Local Government, Housing Corporation, etc., had a locally

elected committee, council or board of directors that was supposed to have considerable responsibility for the local administration of these various departments. Each department was responsible in an ascending vertical structure to their respective territorial minister.

The transient non-Inuit who held the local administrative power in these various sectors of activity viewed their responsibility vertically to their respective bureaucracies rather than horizontally to the political structure of the community. Local-level co-ordination among non-Inuit and Inuit was dependent on personal and social relations rather than structural features of the system. Several case examples are presented below to illustrate the effect that this situation had on the activities of the Nursing Station.

Health education suffered considerably in Pulaktuq because the principal of the school did not encourage the nurses to provide health education to the schoolchildren as part of the school curriculum. His decision appeared to be an expression of his personal estimation of the incompetence of the nurses in areas other than traditional bedside care. This problem was further complicated by the unfortunate personality clash between the principal and the Inuk woman working as the local Community Health Representative. This woman had previously worked as a teacher's aide in the school until she could no longer tolerate the principal's rather authoritarian demeanour. This situation was unfortunate because she thoroughly enjoyed teaching children and, had the opportunity presented itself, would have responded very positively to conducting health-education classes in the school. This lack of co-operation at the administrative level eventually led to private arrangements being made between the nurses and individual teachers to allow either the Community Health Representative or one of the nurses to enter their classrooms for occasional health-education periods. However, this program was by no means systematic or comprehensive, and consequently, it experienced only marginal success.

Co-operation between the nurses and the Department of Social Development staff is mandatory in a number of administrative areas. Social Development is responsible for welfare payments, travel arrangements for returning patients and other social-work activities, such as child welfare, in the community, but ultimate responsibility for these activities is handled by the non-Inuit area supervisor who is located in Qablunaqtuq. In Pulaktuq, an Inuk is hired to assess welfare claims and sign cheques. Theoretically, this person is in training to assume many of the responsibilities currently carried out by the area supervisor, but recent trends towards professionalization in these areas inhibit the possibility that local staff assume real authority. Consequently, the majority of communication between the Nursing Station and the Department of Social Development regarding social problems in Pulaktuq is directed to the area supervisor rather than to the local representative.

The relationship between the Nursing Station and the Hamlet Council (a group of locally elected people responsible for municipal affairs) is again unstructured in nature. The council has no direct political control over the Nursing Station. In a case where the community feels some action regarding Nursing Station problems is required, the council's only recourse is to complain to the territorial government in Yellowknife and hope that the bureaucracy will translate that complaint into action.

The council is responsible for public-health engineering, such as sanitation, sewage and water delivery, which in northern communities is a system beset with problems. The nurses frequently complain to council regarding particular public-health problems, and interaction with the council is a source of frustration to the nurses for several reasons. The chief reason is the dramatic difference in perception of the seriousness of public-health problems between council members and the nurses. Council is responsible for allocating budgetary resources into numerous areas, such as road and airport maintenance, snow removal, recreation and other less crucial activities as well as sanitation, sewage and water delivery. Council members consider these resources less than adequate to carry out effectively all of these responsibilities. The nurses, however, feel that top priority should be given to public-health problems deriving from sanitation and sewage inadequacies.

This conflict is further complicated because one of the most influential council members relies almost exclusively on religious rituals and beliefs when confronted with illness and has little respect for modern medicine. He is particularly resistant to any suggestions the nurses make at council meetings. On the other hand, communication between the nurses and council was sometimes facilitated by the fact that for several years the council chairman was also the janitor-interpreter in the Nursing Station. His influence was ambiguous, however, because it was difficult to determine what effect the role reversal from subordinate to superior had on his participation in council decisions regarding Nursing Station requests. On a day-to-day basis, he would appear to sympathize with the nurses' frustration but did not seem particularly inclined to alleviate that frustration during council meetings.

In the past five years, local-level control has increased over various institutional sectors, such as education and housing. Co-ordination among these agencies has also improved as a result. However, health care remains outside local jurisdiction despite attempts by communities to transfer administrative control locally.[3] As a result, problems in co-ordination continue to occur.

Significantly, there are no formal or informal relationships between the Nursing Station and the two local churches. Both churches are administered by local lay preachers. Despite the apparent religiosity of some of the nurses, attendance at either church is sporadic and infrequent and usually coincides with the visits of priests or bishops. This lack of contact is notable given the important role that religious beliefs now play in illness behaviour.

Internal Factors Affecting Operations of Health-Care Facility

During the period of my fieldwork, there was one nursing staff change-over. The nurse in charge, "Helen," had been there for two years previously. The two field nurses were "Jane" and "Joan."

Relations between the nurses were complicated by the nature of their living arrangements and the nature of their professional attitudes towards their jobs and responsibility to the community. Helen and Jane had markedly different approaches to the concept of health care in a northern community. Whereas Helen leaned towards total involvement in community life, Jane preferred a more structured approach to interaction in which the Station provided a 9-5 service and the nurses were able to dissociate themselves from the community outside of these hours. Practically, this meant that Helen welcomed social visits from Inuit and was more willing to accommodate people professionally outside of scheduled clinic hours. Jane, on the other hand, preferred to visit with the non-Inuit community on her off hours and was irritated by seemingly unimportant medical problems brought to her attention in the evening and at night. Since the nurses had to share living accommodation, their differing philosophies occasionally interrupted each other's personal lives. Jane left Pulaktuq after a one-year term of employment stating that her inability to accommodate and resolve this conflict was her primary reason for seeking a transfer elsewhere.

Joan's approach to community involvement was more in line with Helen's but another source of conflict stemming from Nursing Station dynamics complicated their relationship. Because of Helen's long-time residence in the community (nearly two-and-a-half years when Joan arrived) both the non-Inuit and Inuit components of the community had come to regard the Nursing Station as "Helen's Place." Concomitantly, the population had come to trust Helen's professional abilities and were quite naturally suspicious of any newcomer. Consequently, Joan perceived that the community looked upon her as a "visitor" and/or a "student nurse" for a considerable period of time. Again, because of the shared accommodation, it was impossible for Joan to establish herself independently of Helen's influence, and these attitudes persisted long enough to threaten Joan's professional self-esteem.[4]

The relations between the nurses and the support staff are critical for the effectiveness of the Station. The role of the interpreter is extremely important in cross-cultural health-care delivery. The Pulaktuq Nursing Station was very fortunate to have had an individual who not only was fluent in both Inuktitut and English but was also greatly respected and trusted within the community. Although his job description was that of janitor, his influence on effective communication between the nurses and the community made his presence crucial. Given the rather high turnover normally associated with Inuit employment in the North, his record of ten years of continuous employment in part may reflect the nurses' recognition of his indispensability. As an Inuk, he required considerable time off to fulfill his obligations as a hunter, and his political responsibilities demanded frequent travel to meetings in other communities. Fortunately, the nurses made every effort to accommodate these needs and quite obviously respected his contribution to the effectiveness of health-care delivery in Pulaktuq.

After hours, medical visits to the Nursing Station are often a source of dissatisfaction and complaint from both nurses and Inuit. Theoretically, clinic hours are from ten to twelve every morning, and only emergencies are to be brought to the Station outside of these hours. However, the nurses and the Inuit differ considerably regarding the definition of "emergency." Hardly an evening goes by that the nurse on duty is not required to minister to a minor ailment and an emergency. The nurses' reaction to these demands on their time vary. Medical Services policy, supported now by rules concerning the payment of overtime for emergencies only, suggests that, when the nurse is certain the complaint is not an emergency, she should refuse treatment and tell the patient to return in the morning during clinic hours. In Pulaktuq, this policy is not always adhered to. One nurse compromised by politely lecturing the patient regarding clinic hours and emergencies but at the same time examining the patient and providing the necessary treatment. This occasionally resulted in conflict between nurses when another's approach was more in line with bureaucratic orthodoxy. Consequently, people in the community sometimes viewed those nurses who followed regulations as less helpful and less interested in their needs.

The majority of the off-hour complaints concerned children in some form of emotional distress, which, to an Inuit mother, constitutes an emergency and causes considerable anxiety. The fact that the cause of the distress is nothing more than an upset stomach is not an issue. This reliance on emotional distress as evidence of illness in children manifests itself in other areas that irritate the nurses. Occasionally, a child will be brought to the Nursing Station after hours with a complaint, such as a running ear, that has obviously been apparent for several days. However, to the Inuit mother this malady was not considered serious enough to require medical attention until the child began to exhibit emotional distress — hence, an emergency. It is also important to remember that Inuit sometimes understand children's illnesses to be precipitated by the socially inappropriate behaviour of their parents. Anxiety or guilt surrounding interpretations of this nature may often be a factor leading to requests for emergency treatment or delays in seeking care.

Conclusion

When one examines the contemporary health-care system in the North, the most striking feature is the apparent disappearance of the shamanistic tradition and practices and an almost total dependence on the cosmopolitan medical system. This apparent transition is the result of several factors.

Perhaps foremost is the fact that, in contemporary Inuit society, traditional beliefs surrounding the shamanistic practices (to a considerable extent) are hidden from non-Inuit. Largely because of the history of missionary activity in the Arctic, Inuit are extremely hesitant to express openly their personal views regarding the activities of shamans. This reluctance may have resulted in an underestimate of the extent of traditional health beliefs and practices. However, it should also be understood that the devastating history of development outlined early in this chapter seriously undermined and fragmented the traditional beliefs in the efficacy of shamanistic practices. Cosmopolitan medicine demonstrated an ability to reduce morbidity and mortality significantly in a particularly challenging environment, and, consequently, the Inuit tended to accept its benefits.

The data presented in this chapter, however, clearly indicate that the explanatory model surrounding illness is still primarily concerned with the psychological and social dimensions of illness rather than the mechanistic, biological attributes of disease that are associated with cosmopolitan medicine (cf. Kleinman, 1978). Informants' statements concerning the religious dimensions of some illness and continued explanations that illness is the result of social transgressions attest to this conclusion. As Kleinman suggests, the potential effectiveness of the cosmopolitan health-care system in cross-cultural contexts will be affected by its ability to recognize and respond to traditional explanations for illness. The data presented on the structure and attitudes of the health-care bureaucracy indicate that, where failure does occur, it is as much the responsibility of the adminstrative or bureaucratic elements of the system than of the individual practices of field nurses or the cultural behaviour of the Inuit.

As the data indicate, there are two major themes emerging in northern health care that appear contradictory. On the one hand, there is the realization that the majority of Inuit morbidity is the result of environmental, social and cultural factors that obviously require the health worker's participation in an expanding community role; on the other hand, there is the concern that the Inuit populations are overly dependent on the Nursing Stations for clinical problems and that an effort should be made to encourage self-care and independence from the Nursing Station. The data presented do allow certain tentative conclusions to be drawn regarding these opposing orientations. The personal behaviour of the community nurses and their perceived efforts to be responsive to the health problems, "emergencies" and concerns, as the Inuit define them, are critical in establishing the kind of rapport necessary in order to deal with the broader social issues that are currently affecting health care. George Wenzel (1978) has detailed the response of Inuit in the MacKenzie Delta to the apparent retreat on the part of Medical Services from community involvement and has concluded that this occurrence is negatively affecting the quality of health care in the Delta.

If self-care is the ultimate goal of the health-care system, the transition must be accomplished through radical structural changes that encourage the increased involvement of Inuit individuals and institutions. When the research for this paper was conducted, the Community Health Representative was the sole example of Medical Services' efforts in this area. The successful introduction of the CHR in the health-care delivery system has enormous potential for increasing communication between Medical Services and the community, but by itself, it is insufficient and requires the support of Inuit institutions and other individuals in order to be successful. Communities are beginning to advocate local control over health services, and this initiative should be supported.

Most important, it should always be understood that health care cannot be divorced from the larger social-political and economic realities of the North, characterized by colonialism and paternalism. Improvements in health will be determined only partially by changes in health-care delivery. Changes in health-care delivery must be co-ordinated locally with more comprehensive community development plans.

This realization, perhaps, provides the best explanation for the apparent failure of health-education programs in the North. One frequently heard suggestion is that health education will only be successful when it is packaged in such a way so as to "fit" into both the minds of the Inuit and the life of the community. Although this suggestion has merit, a more realistic interpretation of health-education failures stems from a larger understanding of Inuit priorities in contemporary northern history. Faced with overwhelming changes in every dimension of their lives, and the consequent need to "learn" and create new behavioural strategies in order to cope with these changes, the Inuit appear quite satisfied to leave matters of health and illness to the Nursing Station. For most people, comprehending the complexities of germ theory and preventive medicine is low in priority when their energy and attention is focussed on the social, political and economic upheavals occurring around them.

The insight that the foregoing analysis gives us into cross-cultural health care concerns the importance of understanding the culture of both sides of the delivery process — providers and consumers — in order to comprehend local-level dynamics. For instance, the conflict between the bureaucratic philosophy of noninvolvement and the personal commitment of some of the field nurses to involvement in all aspects of community life resulted in several local misunderstandings and a crippling of the effectiveness of local health programs.

The analysis also indicates the importance of proper cultural orientation if field staff are to acquire a sophisticated understanding of the dynamic nature of culture in order to understand and evaluate adequately the behaviour of their clients. Further, it is vital that field staff understand the manner in

which they are perceived by their clients in order to avoid the sort of misconceptions and confusions that can arise when their behaviour is subject to misinterpretation.

Although most of the material reported on here was collected in 1978, changes at the local level have not been significant enough to warrant drastic revision. The paper is neither historically circumscribed nor idiosyncratic; it continues to describe the general characteristics of health care in isolated Inuit communities. The most significant feature of this system is the structural separation between providers and clients of health services at the local level. Although some health professionals and some Inuit clients find ways to communicate and interact on a co-equal basis, the system continues to discourage such interaction.

This is not to suggest that changes are not occurring in the broader arena of native health care in Canada that may influence the local situation eventually. These changes can be summarized briefly in three key areas:

1. Self-determination is the central theme in all areas of political, economic and socio-cultural development. Indian and Inuit communities in Canada have been negotiating hard for the right to control development in these key sectors for the past decade and appear to be on the brink of achieving long-lasting structural changes. Since the structure of health services reflects the larger political economy, radical changes in health-care services are imminent (e.g., the Cree Health Board in northern Quebec is a product of the settlement of land claims).
2. Transfer-of-control demonstration projects have been set up across the country by the Medical Services Branch, Health and Welfare Canada, to evaluate the problems involved in local administration of health services by native communities. While these projects have been criticized by Indian representatives as stalling tactics designed to impede real transfer of control initiatives, they are nevertheless contributing to the realization that an across-the-board change of this nature is inevitable.
3. Medicalization and professionalization of health is increasing in northern regions. This change is perhaps the most disturbing from the standpoint of health needs at the community level. Frustrated with the colonial structure of health services in their communities, Inuit representatives are rejecting the nurse-practitioner/midwife model of primary care described above and are advocating for more doctors, hospitals and medical technology.

The tragic contradiction in these trends is perhaps not obvious. Although the "Nursing Station" model described above has long been the most visible

symbol of the colonial structure of northern health services to people in the communities, from a broader perspective it could provide an ideal model for primary health care within a more community-oriented system. Indeed, many of the conflicts experienced by field staff in their relations with administration were a symptom of this ironic flaw in the structure of northern health services.

Despite its colonial associations, the "Nursing Station" model is much better adapted to facilitate a responsive community-based system of primary and preventive health care. If local communities continue to experience resistance in their transfer of control initiatives, however, the symbol of resistance is likely to become the Nursing Station — with the tragic result of achieving local control over a less flexible system structured to protect the professional and technological interests of doctors and hospitals.

Notes

[1] Other ethnographic reports (Balicki, 1963) suggest that the *Kilaruq* was parashamanistic in nature and considered beneath the shaman's expertise. However, informants in Pulaktuq attributed its practice primarily to shamans.

[2] Pulaktuq lacked an RCMP detachment, which is also a federal responsibility, until 1982.

[3] For a detailed discussion of the transfer of control issue in the health-services sector, the reader is referred to several papers published in the *Canadian Journal of Public Health*, 1986 (forthcoming).

[4] Medical Services is now trying to provide private accommodation for northern nursing staff. In Pulaktuq, however, staff conflicts continue to be generated by the shared accommodation arrangements.

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8

Patient Pathways: Abortion*

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Decisions about unwanted pregnancies involve heightened emotions and considerable stress. After an unwanted conception has occurred, women may follow one of several courses that, in part, depend upon their social situation, what they know about different options and the availability of the health services where they live. Some women obtain an abortion directly in a Canadian hospital. Others who are less familiar with health services turn to community agencies for counsel. Some women by-pass Canadian medical-care services altogether and go to the United States. In decreasing numbers, a smaller group of women turn for assistance to maternity homes.

In reviewing these options, which are taken following conception, three other courses are not dealt with in detail in the Report. Little is known about how many women had unwanted pregnancies, whether they were single or married or if they gave birth to a child, but at no time sought the assistance of community agencies. Another group about whom little is known are the women who had abortions in Canadian hospitals that were listed as being neither spontaneous nor induced. Finally, a group whose numbers are diminishing are the women who obtain illegal abortions in Canada.

The general pathways taken by women who have unwanted pregnancies are: 1) women who are referred directly for abortions in Canadian hospitals;

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